Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE ADMINISTRATIVE APPEALS

ALJ Hearing Process

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Inspector General

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PURPOSE

To evaluate the administrative law judge appeals process for Medicare Part B and Medicare Part A fee-for-service claims.

BACKGROUND

If an intermediary or a carrier denies payment for a claim, a provider or a beneficiary may appeal the denial. The appeal procedure for Part A and Part B claims is different. Regardless of the procedural route, however, providers and beneficiaries may appeal to HCFA contractors, Administrative Law Judges, and the Departmental Appeals Board of the Department of Health and Human Services.

The first step in a beneficiary or provider appeal is a request for a reexamination of a denied claim. The request, called a reconsideration, is made to intermediaries for Medicare Part A claims. The request is made to carriers for Medicare Part B claims. For Part B claims, the request is called a review.

If a Medicare intermediary upholds a denied Part A claim, the next step is to request a hearing with an Administrative Law Judge. If a Medicare carrier upholds a denied Part B claim, there is an additional level of appeal. This appeal is made to a carrier hearing officer. If the carrier's hearing officer upholds the denial, the appellant may then request a hearing with an Administrative Law Judge.

If an Administrative Law Judge upholds a denied Part A or Part B claim, an appellant may request a review by the Departmental Appeals Board. The Departmental Appeals Board is the final level of administrative appeal.

FINDINGS

Increasing Number and Changing Nature of ALJ Appeals

An increasing number of appeals are being heard by ALJs. In addition, a large percentage of these appeals are reversed and payments made to appellants. Further, although the appeals process was established as a non-adversarial system for beneficiaries, it is now a provider dominated process.

Structural Inconsistencies in the Appeals Process

A number of elements contribute to inconsistencies in the appeals process. The elements include; lack of consistent criteria for contractors and Administrative Law Judges, lack of communication by parties in the appeals system, and lack of precedence of Administrative Law Judge cases.

Non-Adversarial Nature of Administrative Law Judge Hearings

Medicare is not a party to ALJ hearings. Therefore, the non-adversarial structure of the appeals process often requires that Administrative Law Judges serve as fact finders and neutral decision-makers. However, this practice may compromise the neutrality of Administrative Law Judges by forcing them to present Medicare's case at hearings, then decide the case. Parties in the appeals process agree that non-adversarial hearings are a problem.

Minimal Experience and Training of Administrative Law Judges

On average, Administrative Law Judges spend about 8 percent of their time adjudicating Medicare cases. Their focus is on adjudicating Social Security Administration disability cases. Further, Administrative Law Judges receive neither extensive formal nor informal training on Medicare.

RECOMMENDATIONS

Correct structural problems:

- Separate the administrative appeals process for beneficiaries and providers.
- Establish adversarial ALJ hearings for provider appeals.
- Develop and require both Medicare contractors and ALJs to apply the same standards.
- Develop regulations for conducting Medicare ALJ appeals.
- Establish a case precedent system for Departmental Appeals Board rulings.
- Develop thorough, parallel training programs for Medicare contractors and ALJs.
- Create formal communication and information networks that span the entire appeals environment.

Establish a dedicated ALJ corps: We submit three organizational options for such a corps:

1. Establish an ALJ corps in HHS for Medicare cases.
2. Create a dedicated corps in SSA for Medicare cases.
3. Expand the current Part B cadre of ALJs in SSA to handle all Medicare cases.

INTRODUCTION

PURPOSE

To evaluate the administrative law judge appeals process for Medicare Part A and Medicare Part B fee-for-service claims.

BACKGROUND

Medicare Part A benefits include home health care, inpatient hospital care, inpatient psychiatric care, skilled nursing care or rehabilitation associated with recuperation following hospitalization, and hospice care for the terminally ill. This inspection considered only the home health benefit under Part A. The Health Care Financing Administration (HCFA) contracts with five Regional Home Health Intermediaries to process and pay home health claims under Medicare Part A.

Medicare Part B benefits include physician services, outpatient services, diagnostic laboratory tests, x-rays, ambulance services, and durable medical equipment. The HCFA contracts with 23 carriers to process and pay Medicare Part B claims.

Medicare expenditures for FY 1997 were over $210 billion.

Appeals Process

If an intermediary or a carrier denies payment for a claim, a provider or a beneficiary may appeal the denial. The appeal procedure differs for Part A and Part B claims. Regardless of procedure, however, the administrative appeals process has a specified order. Appellants must begin with the HCFA contractor before going to the Administrative Law Judge (ALJ). After the ALJ hearing, cases may be appealed to the Departmental Appeals Board of the U.S. Department of Health and Human Services.

ALJs are employed by the Social Security Administration (SSA), but they adjudicate Medicare appeals under a contractual arrangement.

The first step in a beneficiary or provider appeal is a request for a reexamination of a denied claim. The request, called a reconsideration, is made to intermediaries for Medicare Part A claims. The request is made to carriers for Medicare Part B claims. For Part B claims, the request is called a review. There is no minium dollar amount required to request a reconsideration or a review.

If a Medicare intermediary upholds a denied Part A claim, the next step is to request a hearing with an ALJ. In other words, after the intermediary reconsideration, providers and

beneficiaries may appeal denied Medicare Part A claims directly to ALJ offices. The appeals are not reviewed by, or routed through, any other Federal organization or representative.

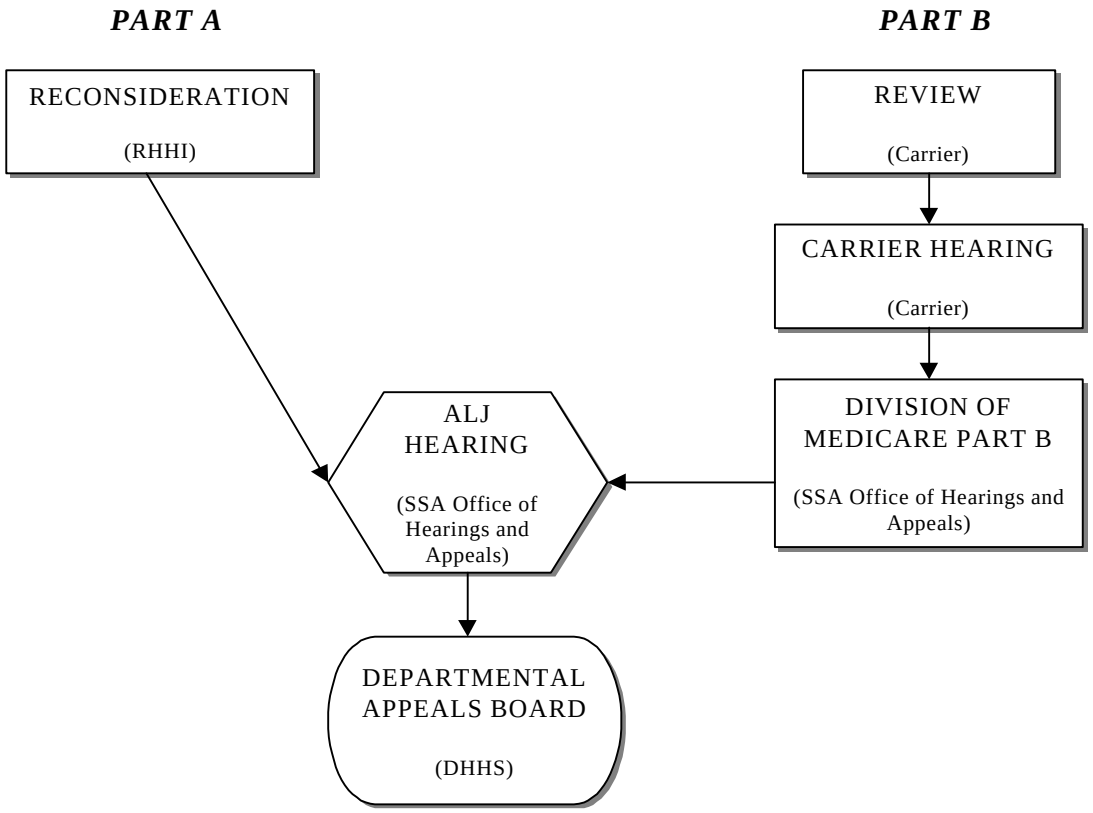
If a Medicare carrier upholds a denied Part B claim, there is an additional level of appeal. This appeal, requiring $100 or more in controversy, is made to a carrier hearing officer. If the carrier hearing officer upholds the denial, the appellant may then request a hearing with an ALJ.

To qualify for an ALJ hearing, the dollar amount in controversy must be $100 or more for Part A appeals and $500 or more for Part B appeals. Under certain conditions, the dollar amount of several claims may be aggregated to meet the threshold. A beneficiary may aggregate claims from two or more providers to meet the threshold. A provider may aggregate claims from different beneficiaries regardless of the service at issue.

However, before most Medicare Part B appeals are reviewed by an ALJ, case files are sent to the Division of Medicare Part B within the SSA Office of Hearings and Appeals located in Falls Church, Virginia. Cases are assigned a docket number and reviewed for procedural issues at the Division of Medicare Part B. After docketing and review, the cases are sent to the an ALJ office for hearing. Large Part B cases remain at Falls Church for assignment to a cadre of ALJs who specialize in larger cases. Staff at the Division of Medicare Part B also provide training and serve as an information resource for ALJs.

If an ALJ upholds a denied Part A or Part B claim, an appellant may request a review by Administrative Appeals Judges of the Departmental Appeals Board. The Departmental Appeals Board consists of a corps of judges and attorneys attached to the Office of the Secretary, Department of Health and Human Services.

LEVELS OF MEDICARE ADMINISTRATIVE APPEAL



If the Departmental Appeals Board refuses to hear an appeal, or upholds a denial, the administrative appeal process is over. An appellant may, however, seek judicial review in Federal Court if the amount in controversy is above $1000.

Impact of Administrative Appeals

The cost to HCFA for administrative appeals is sizable. First, HCFA incurs a considerable administrative cost through its contractors for processing appeals. To illustrate, the administrative cost incurred by HCFA for administrative appeals totaled over $4 million for Medicare Part A and about $75 million for Medicare Part B in FY 1996. The HCFA incurs this contractor administrative cost regardless of how appeals are ultimately decided.

The HCFA also incurs a cost for use of ALJs employed by SSA. The SSA is reimbursed from the Medicare Trust Fund for ALJs who adjudicate appeals of Medicare payment decisions. This administrative cost totaled over $9 million for Medicare Part A and almost $15 million for Medicare Part B in FY 1996.

Cost is not the only issue or cause for concern over the Medicare appeals process. The high rate of reversal during the appeal process is a concern for HCFA and its contractors. According to HCFA representatives, the high rate of reversal may provide an incentive for uninformed or abusive providers to submit claims for services and items that are not covered.

In addition, contractor staff are increasingly demoralized by a high incidence of ALJ reversals. Contractors report seeing providers who have been in the Medicare program for years use the administrative appeals process to "beat the system" and obtain payment for services and supplies which are not payable under contractor guidelines.

The following table shows the volume of claims in the appeals process in FY 1996.

Volume of Claims in Appeals Process
FY 1996

	PART A Overall	PART A Home Health Claims Only	PART B
# Claims Processed	142,086,669	14,680,576	666,664,972
# Claims Denied	13,457,514	377,185	97,636,027
# Reconsiderations Performed	60,680	30,903	NA
# Reviews Performed	NA	NA	3,638,363
# Hearing Officer Hearings	NA	NA	70,716
# ALJ Hearings	12,155	4811	16,360

METHODOLOGY

We used a standardized mail questionnaire and surveyed all five Regional Home Health Intermediaries that process Part A claims for home health services, all 23 carriers who process Part B claims, and a random cluster sample of ALJs.

We also surveyed all 28 cadre judges. Cadre judges are a separate population of SSA ALJs. They spend a larger percentage of their time adjudicating Medicare appeals than the general population of ALJs. Furthermore, cadre judges adjudicate the most complex and highest dollar Part B appeals.

From each of the sources, we obtained information on training and resources, conducting the appeals process, communication, and suggestions for improving the appeals process.

In sampling the ALJs, we used a one-stage cluster sample. First, we randomly selected 30 hearing offices from the universe of 135 hearing offices across the U.S. that handle Medicare appeals. Second, we mailed surveys to all 284 ALJs assigned to the 30 sampled hearing offices. Of the 284 sampled ALJs, 123 responded to our survey -- a response rate of 43 percent.

Because of this poor response rate and quality of the data, we didn't project the ALJ survey to the general population or provide any estimates based upon that information. All information collected from that survey is presented as anecdotal comments.

Additionally, we surveyed all 28 Medicare cadre judges. Of the 28 cadre judges, 24 responded to our survey -- a response rate of 86 percent.

We also interviewed HCFA headquarters and regional office representatives, HCFA Medicare contractors, Office of Hearings and Appeals and Departmental Appeals Board representatives, and the ALJ in charge of the SSA Division of Part B Medicare Appeals.

We tabulated and summarized the information we collected from our contractor and ALJ surveys. We also compared the responses we received from each group we interviewed and surveyed.

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We did our study between January 1998 and January 1999. We conducted the inspection in accordance with *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency**.**

FINDINGS

Increasing number and changing nature of ALJ appeals

Appeals and reversal of claims decisions are increasing

An increasing number of appeals are being heard by ALJs. This may be due to the high rates of contractor denials for payment which are reversed by ALJs. Providers may be motivated, in part, to appeal to the ALJ level, knowing their claim is likely to be paid. There has been no commensurate increase in appeals at lower levels.

The following table demonstrates the sizable increase in the number of ALJ hearings between FY 1996 and FY 1998.

Number of ALJ Hearings for Medicare Part A and Part B

	1996	1997	1998	increase 96-97	increase 97-98	increase 96-98
Part A	12,155	15,725	16,755	29%	6.5%	38%
Part B	16,360	28,256	32,498	73%	15%	99%
Total	28,515	43,981	49,253	54%	12%	73%

In addition, a large percentage of appeals reaching the ALJ level are reversed and payments made to appellants. To illustrate, in 1996, 81 percent of home health appeals were reversed at the ALJ level. In 1997, 78 percent of Durable Medical Equipment appeals were reversed at the ALJ level. Reversal rates of this magnitude could encourage appellants.

Providers are now the primary appellants

The Medicare administrative appeals process was established for the beneficiary. Its structure is non-adversarial. This means that appellants may present their appeal at a hearing without presence or opposition of the adverse party. It allows beneficiaries to present relevant information in support of their appeal without fear of intimidation by the Government and its agents. Medicare is not even represented at ALJ hearings. Only a written record of the claim and prior levels of appeal are presented. Most respondents viewed non-representation by Medicare as an important protection for beneficiaries.

However, the appeals process is no longer a process predominately for beneficiaries. It is now a provider process. The SSA Office of Hearings and Appeals and HCFA contractors

do not collect reliable statistics on what percentage of appeals are made by providers as opposed to beneficiaries. However, all the respondents to our questionnaires agreed that beneficiaries make up a very small percentage of appellants.

Providers do bring beneficiaries to some ALJ hearings along with expert witnesses and attorneys. However, many ALJs and contractors do not consider the presence of beneficiaries to indicate a beneficiary appeal.

With providers making up the preponderence of appellants, one noticable trend is a cause for concern. Some providers appeal aggressively, challenging a large percentage of denials. Contractors report providers do so because of success with prior appeals at the ALJ level.

The noteworthly media attention concerning high ALJ reversal rates may encourage providers to appeal. In addition, there are many appeals consultants informing providers and their attorneys on the great liklihood of a favorable ALJ decision, and the best ways to present their case at hearings.

Structural inconsistencies in the appeals process

Contractors and ALJs use different criteria in making coverage determinations

In many instances, Medicare contractors and ALJs use different criteria in ruling on Medicare payment and coverage issues. This, in part, accounts for the high level of reversed claim decisions by ALJs.

Medicare contractors use Medicare law, HCFA regulations, HCFA rulings, and national coverage determinations as criteria in making claim decisions and in ruling on appeals. Where applicable, they also rely heavily on contractor manuals and local medical review policy because they are required to use these standards.

The ALJs also use Medicare law, HCFA regulations, HCFA rulings, and national coverage determinations. However, they rarely use contractor manuals and local medical review policy because they are not bound by these standards, as are contractors. As a result, ALJ decisions typically reflect use of a much broader and less prescriptive criteria.

The extent to which Medicare contractors and ALJs do not use the same criteria in ruling on claims could partly explain why ALJs overturn claim decisions made by Medicare contractors. A contractor can follow contractor requirements perfectly and come to a different conclusion than an ALJ who has followed his/her less prescriptive requirements perfectly. This commonly results when contractors base decisions on local medical review policy, which is not binding on ALJs. For example, contractors note cases they decided using the required local medical review policy which were overturned by ALJs. The ALJs were not required to apply the criteria used as the basis for the decision at the contractor level. In fact, the ALJ may not even have access to local medical review policy.

Further complicating the problem of inconsistent criteria, HCFA has issued no ALJ appeals regulations for conducting Medicare ALJ hearings. Therefore, ALJs must rely on SSA disability regulations in conducting ALJ hearings.

The DHHS Departmental Appeals Board and the SSA Office of Hearings and Appeals agreed that the absence of specific criteria and guidance partly accounts for the inconsistent decisions by Medicare contractors and ALJs. Further, the individual ALJs who responded to our survey also said that specific criteria and guidance is needed to help them more consistently adjudicate cases.

Medicare's ability to defend its appeal determinations is limited

A number of factors increase the likelihood of appeals being reversed in favor of providers. First, providers are afforded the same appeal rights as beneficiaries, including the right to a non-adversarial hearing. Second, providers may present their case at hearings and be represented by attorneys and expert witnesses. Beyond the written record, Medicare is typically not represented at ALJ hearings. A third advantage is that providers are allowed to rebut testimony contained in the contractor's written record.

Yet another advantage for provider appellants is that they are allowed to use a number of sophisticated means, including statistical analysis and legal arguments to make their cases. These arguments are tailored for the case in question. One Part B cadre ALJ said, "providers are hiring the best law firms to represent their interest." Another said, "providers and suppliers have the resources to present their cases with the assistance of sophisticated counsel and/or experts." In fact, many ALJs who responded to our survey commented that provider representation is outstanding and one-sided.

In contrast to the right of provider appellants to be represented at ALJ hearings, the appeals process typically allows no opportunity for HCFA and its contractors to rebut provider evidence and arguments. Although an ALJ may invite a Medicare contractor to a hearing, such invitations are uncommon. Further, when invited, the contractors typically send a nurse or a physician to represent them, not an attorney or other legal expert. Finally, the ALJ determines what role these invitees have in the hearing, which is usually clarification of some part of the Medicare record or program.

While contractor representatives are often experts on the Medicare program frequently, they have little experience in a legal setting. Contractor staffs and ALJs told us such representatives may be overwhelmed when confronted and challenged by provider attorneys. Contractor representatives may also have their testimony countered by other expert witnesses on behalf of the provider. In any case, the appeals process does not allow Medicare to challenge the provider witnesses.

Precedence from prior cases is not considered In ALJ hearings

Although the appeals system is hierarchal, ALJ decisions do not set precedent. Further, the Departmental Appeals Board, the highest level of Medicare administrative appeals, does not have precedent setting authority.

Several Medicare contractors expressed a view that the lack of precedent setting authority contributes to inconsistent ruling by ALJs. This variation undermines the Medicare appeals process and may contribute to other questionable practices. For example, one Durable Medical Equipment Carrier medical director advised us that some abusive providers engage in ALJ shopping. In other words, they actively look for an ALJ who renders favorable rulings on their particular type of claim.

Representatives of the Departmental Appeals Board also said that ALJ rulings on similar Medicare cases may be very different. To illustrate, they described a situation where the Departmental Appeals Board reversed an ALJ decision in a narrow and definitive way. Shortly thereafter, on a similar case, another ALJ rendered essentially the same ruling that the Departmental Appeals Board had just reversed. In this example, the second ALJ ruling will stand unless it is also appealed to the Departmental Appeals Board and overturned.

Departmental Appeals Board respondents to our inspection voiced strong interest in having precedent setting authority in order to clean-up inconsistencies and other problems in the appeal process.

Appeals process suffers from limited communication

The lack of communication about Medicare issues within the ALJ corps promotes inconsistency. There are no conferences or national newsletters addressing Medicare for SSA judges. This may reflect the lower priority given to Medicare in the SSA ALJ corps. The exception to this is the Part B ALJ cadre where attention to Medicare receives a priority in the form of resources and communication among the judges. The cadre could be a useful model for improved functioning of the Medicare appeals process.

Another useful model for improved communication is Transamerica of California. This contractor, by their own initiative, improved communication with local ALJs.

EFFECTIVE PRACTICE:

Transamerica of California

One HCFA contractor, Transamerica Occidental of California, improved the preparation of their case files by improving communication with local ALJs. This Part B carrier began a dialog with ALJs in November of 1995. The dialog was initiated by the carrier in an effort to better understand the basis for ALJ decisions. The meetings and workshops also provided the contractor an opportunity to learn the structure and content of appeals files which would be most instructive and helpful for ALJs who heard appeals of their decisions.

As a result of the interaction and training, Transamerica developed a file preparation format. It was more specific than that required by HCFA. Each file sent to an ALJ contained a case summary which clearly profiled the cases, and noted the specific issue before the ALJ. To aid use of the files by ALJs, the contractor used plainly marked and tabbed exhibits. Both the SSA Office of Hearings and Appeals and HCFA commented that case file preparation by this Medicare contractor has shown great improvement.

The interaction and training also included educating ALJs on the basis and rational for Medicare contractor decisions. Further, it educated ALJs on the type and content of contractor files and documents. The ALJ workshops are comprehensive, covering topics such as claims processing, carrier medical review process, local medical review policies, and sample case analysis. The chief hearing officer at Transamerica told us that the ALJs were, “thirsty for knowledge”.

Since 1995, Transamerica has continued to conduct the educational workshops for contractor staffs, ALJs, and additionally, for Office of Hearings and Appeals attorneys and legal assistants.

Transamerica reports that the enhanced understanding by ALJ and Medicare contractors, and the enhanced case file preparation has made a difference. Agreement between the Medicare contractor and ALJs on Medicare claims has increased markedly. To illustrate, at this Medicare contractor ALJ reversals on claim decisions decreased from 59 percent in FY 1994 to 31 percent in FY 1997.

Non-adversarial nature of ALJ hearings

ALJs must present the Medicare case at hearings

The ALJs must serve as fact finders and neutral decision-makers because Medicare is not a party to ALJ hearings. The contractor can neither present their case nor rebut the provider's case. Because the contractor decision is represented only by a written record, the ALJs, in effect, are required to present Medicare's case from that record. The ALJ is also required to rebut the provider's arguments, should he/she choose to do so. When experts are needed to interpret the written record, it falls to the ALJ to locate such experts, or to depend on whatever experts the provider presents. After the excessive burdens imposed by the steps listed above, the ALJs remain faced with their primary task, which is to decide the case.

Parties in the appeals process agree that non-adversarial hearings are a problem

Several ALJs said that Medicare should be allowed representation, and should be a party to ALJ hearings. In fact, all Part B cadre ALJs responding to the survey said that having Medicare represented at hearings would help them adjudicate cases. The judges said that the non-adversarial hearings place them in the difficult position of presenting Medicare's case, and place Medicare at a disadvantage. Comments from ALJs include the following.

- "Medicare cases do not fit anymore into the non-adversary model because the issues are often extremely complex and it places an undue burden on the ALJ to assume the role of advocate and adjudicator in the same case."

  "Without question, the contractor or HCFA should be a party to the proceedings and allowed representation. There are millions [of dollars] at stake and the record should be balanced before a decision is made. Medicare should be actively present in selected cases."

  "Government is at a distinct disadvantage as evidence of record becomes very one sided."

Contractors also want a more balanced ALJ hearing process. Eighty-five percent of HCFA contractors reported that the ALJ hearing process would benefit from contractor participation at ALJ hearings.

Finally, representatives of DHHS's Departmental Appeals Board and SSA's Office of Hearings and Appeals also consider the non-adversarial hearings to be weighted in favor of providers. They noted the increasing complexity of cases, particularly in Part B, as a cause for re-structuring the non-adversarial nature of hearings for providers.

Minimal experience and training of Administrative Law Judges

ALJs primarily adjudicate Social Security cases

Medicare cases comprise a small percentage of the SSA ALJ corps' time. The ALJ corps spends about 8 percent of its work time hearing Medicare cases. To illustrate, during 1996, SSA ALJs adjudicated 365,284 SSA cases and 28,515 Part A and Part B Medicare cases.

Accordingly, ALJs have limited experience with the Medicare program — its policies, rules, and claims. The inexperience of ALJs was clearly reflected by their response to our survey. Of the general ALJ corps, only 43 percent of the ALJs responded to our survey. Further, of those that did respond, their responses were brief, sketchy, and generally incomplete.

ALJs focus on adjudicating SSA disability cases

The ALJ corps was established to hear SSA cases, and its growth has been principally due to the large number of SSA disability appeals. The ALJs frequently receive congressional pressure to reduce the backlog of disability appeals. As a result, several ALJs responded to our survey by reporting that they were under pressure to keep up with their Social Security disability caseload. Medicare cases are a secondary concern. One ALJ summed up the situation by simply stating "Medicare is not a priority."

The lower priority of Medicare cases was further illustrated by SSA's Office of Hearings and Appeals response to our efforts to obtain information from individual ALJs. Overall, the Office of Hearings and Appeals was very cooperative and helpful in encouraging its ALJ corps to respond to our Medicare survey. Even so, its assistance reflected that the Office of Hearing and Appeal's priority was SSA cases. To illustrate, because of concern about the heavy year-end SSA case load, the Office of Hearings and Appeals delayed sending a notice to its ALJ corps encouraging them to complete our survey questionnaire.

ALJs are inadequately trained and equipped for adjudicating Medicare cases

Many of the ALJs and Medicare contractors we surveyed agreed that one of the most serious problems with the Medicare administrative appeals system is the unfamiliarity with Medicare by most of the SSA ALJ corps. The ALJs receive neither extensive formal nor informal training on Medicare.

Many judges contend that they lack sufficient training on Medicare. In fact, most judges receive only 1 or 2 days of formal training. Given the complexity of the Medicare program, this amount of training seems grossly inadequate.

The ALJs point out that on-the-job training is also inadequate. For most ALJs, the on-the-job training and experience is not extensive. According to SSA workload data, the average ALJ spends only about 8 percent of his or her time hearing Medicare cases. This equates to about 18 work days a year on average.

Many of the ALJs told us that resources which could help them come to informed rulings are also lacking. They said, for example, they frequently do not have access to useful Medicare resources such as HCFA rulings, HCFA cd-rom, contractor manuals, and contractor publications. Some of the ALJs did tell us that they had access to some of these resources, but most did not have them available and were not using them. Further, where contractors have manuals to guide them though the appeals process, no comparable manual exists for ALJs.

EFFECTIVE PRACTICE:

Part B Cadre

In part to enhance the Medicare expertise of the SSA ALJ corps, SSA's Office of Hearings and Appeals has taken some positive and helpful actions. For example, in March, 1998, SSA established a special cadre of ALJs to hear complex, high dollar Medicare Part B cases. A case must have at least $40,000 at issue and involve over 30 beneficiaries to be adjudicated by a cadre judge. The cadre, comprised of 28 ALJs, received additional training and laptop computers with Internet access to HCFA resources.

Although not exclusively dedicated to Medicare hearings, the Part B cadre focuses more of its time on Medicare than does the general ALJ corps. This focus promotes development of Medicare expertise. The cadre judges demonstrated a high degree of knowledge and concern for the Medicare program. By contrast to the general ALJ corp of judges, the Part B cadre responded in high numbers to our Medicare survey (89 percent vs 43 percent). Further, their responses to our survey questions were much more informed and helpful than those from SSAs general ALJ corps.

Further, the cadre judges have considerable interaction and communication about the cases they adjudicate. Cadre judges share information through e-mail correspondence and electronic bulletin boards specific to cadre judges. They exchange information about particular types of cases to guide other cadre judges hearing similar cases.

RECOMMENDATIONS

Correct structural problems: The following recommendations will help correct structural weaknesses in the administrative appeals process. Unless corrected, these weaknesses will continue to adversly affect the administrative appeals process.

- **Separate the administrative appeals process for beneficiaries and providers.** This would allow beneficiary appeals to remain a non-adversarial appeal system which many of our respondents deemed so important. It would also allow HCFA to re-design an appeal system for providers and provide for a balanced hearing that fairly represents all parties, including Medicare.

- **Establish adversarial ALJ hearings for provider appeals.** As recommended by many of the ALJs we surveyed, adversarial hearings are needed to assure fair and impartial hearings for all parties. The current non-adversarial process is one-sided and heavily weighted in favor of the provider. Further, under the current system, the ALJ is often burdened with both presenting Medicare's case as well as trying to make an impartial decision based on one sided evidence.

- **Develop thorough, parallel training programs for Medicare contractors and ALJs.** HCFA can best determine what training is needed by each group. However, the need for imparting consistent information to all parties in the appeals process is clear. This is particularly true because the appeals process is a hierarchical process in which common knowledge and information is important.

- **Develop and require both Medicare contractors and ALJs to apply the same standards.** In much the same fashion as common training elements are important to the process, so too, are common standards upon which to base decisions. Again, because this process is hierarchical, the application of the same rules by all parties for decision-making is very important.

- **Develop regulations for conducting Medicare ALJ appeals.** Medicare claims are increasingly complex and costly. As this trend continues, HCFA is likely to see more and more inconsistent rulings on appeals because of the absence of specific regulations to guide the appeals process.

- **Establish a case precedent system for Departmental Appeals Board rulings.** By establishing precedence and means for communicating prior decisions, HCFA could keep the appeals pipeline clear of many "mistaken" decisions. The system could operate much like the court system currently operates. We believe the

practice of case precedence becomes very important in hierarchical hearings process.

- **Create formal communication and information networks that span the entire appeals environment.** Enhancing the knowledge of all parties in the appeal process should help assure consistency in appeal rulings.

Establish a dedicated ALJ corps: Considering the increasing importance and cost of Medicare cases, it is time to consider more effective and cost efficient ways to allow beneficiaries and providers to appeal Medicare decisions. We believe that the best way to improve the appeal function is to create a dedicated corps of ALJs who exclusively adjudicate Medicare. We suggest three organizational options for this corps.

1. Establish an ALJ corps in HHS.

   - It could be in the Office of the Secretary and handle all Departmental Administrative Law Judge hearings.

   - It could be free standing within the Department, and handle all Departmental Administrative Law Judge hearings.

   - It could be in HCFA and handle exclusively Medicare and Medicaid Administrative Law Judge hearings.

2. Create a dedicated corps in SSA, where some superstructure already exists. This corps would address only Medicare cases.

3. If HHS does not establish its own dedicated corps and does not negotiate for one in SSA, it should examine expansion of the current Part B cadre to handle all Medicare appeals. While this would be an improvement, the current Part B cadre judges in SSA are not dedicated to Medicare. Therefore, Medicare cannot be assured the priority that would be available under a dedicated ALJ corps.

Regardless of organizational location, the structural changes discussed above should be corrected. In so doing, care must be taken to maintain the independence of the appeals process which has been evident in the Social Security ALJ corps, and at the same time make needed improvements.

AGENCY COMMENTS

HCFA concurred with our recommendations. Their comments are in Appendix A.

APPENDIX A

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: AUG 9 1999

TO: June Gibbs Brown
Inspector General

FROM: Michael M. Hash
Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicare Administrative Appeals," (OEI-04-97-00160)

HCFA greatly appreciates the work that the Office of the Inspector General (OIG) has done in reviewing the Medicare Administrative Appeals Process and your valuable and timely recommendations. We agree with the OIG that the process has serious weaknesses, and that the most significant problems involve the Administrative Law Judge (ALJ) stage of the appeal process. HCFA is committed to improving the entire appeals process.

We have already taken several important steps in the right direction. As the OIG notes in the report, we have worked with the Social Security Administration (SSA) to establish a cadre of 30 Medicare-only specialist ALJs who handle the most complicated of Medicare's Part B cases. This cadre has proven very successful as evidenced by their efficiency and technical, well-written decisions. We have enhanced our instructions to contractors in the area of appeals, adding new requirements to ensure that case files are complete and comprehensive. We are also training contractors on how to properly develop a file for ALJ review. Finally, we have invited ALJs to several Medicare education programs and plan to conduct more training for ALJs in the future. We believe that the better ALJs understand the Medicare program, the better their decisions will be.

Although the purpose of the report was to evaluate the ALJ process for Medicare fee-for-service (FFS) appeals, many of the recommendations for improving the ALJ level of appeal would equally apply to Managed Care ALJ appeals, including, for example: HCFA having its own corp of ALJs, parallel training of ALJs and managed care organizations (MCOs), and application of the same standards by MCOs and ALJs.

Overall, we concur with the OIG's recommendations, and we have the following specific comments and plans of action with regard to those recommendations:

OIG Recommendation
Correct Structural Problems

HCFA Response

- Correcting Structural Problems -
  We agree with separating the administrative appeals process for beneficiaries and providers, in order to maintain a non-adversarial appeals process for beneficiaries, while re-designing an appeal system for providers that fairly represents all parties, including Medicare. Beneficiaries should continue to benefit from the non-adversarial system that is currently in place. We agree that HCFA or its contractors should have the opportunity to be represented in cases before ALJs where the appellant is a provider. Currently, even in cases involving significant policy or significant amounts of money, HCFA's case is often presented only on paper. As the OIG notes, the reason HCFA does not currently have the right to appeal is that hearings are conducted according to SSA regulations that were designed to protect beneficiaries. In the Medicare context, where most appellants are providers, these regulations unreasonably restrict HCFA's participation. We believe that Medicare ALJ appeals should be governed by HCFA regulations, and we will develop such regulations by the end of the year. A key feature will be a requirement that HCFA be made a party to hearings when the appellant is a provider. The contractor will have the right to appear in, as well as the right to appeal, all cases where the Medicare policy is not upheld.

- Establish Adversarial ALJ Hearings for Provider Appeals -
  As discussed above, we agree that the contractors should have the right to participate in hearings when they so choose, and we will develop regulations in this regard. As a party, HCFA and its contractors should be able to appear at hearings represented by counsel, introduce evidence, testify, cross-examine witnesses, and submit written briefs and motions.

- Develop Thorough, Parallel Training Programs for Medicare Contractors and ALJs -
  We agree that ALJs need much more training in Medicare issues and we will make a commitment for vigorous and ongoing training and education for ALJs and their staff. In fact, ALJs have recently attended training in such areas as statistical

sampling and partial hospitalization. In addition, HCFA will hold a two and a half day National Fee-for-Service Appeals Conference for our contractor staff in September, 1999. We believe it is crucial for HCFA to commit to ALJ training. Currently, HCFA provides sporadic training to ALJs who volunteer to be trained. By placing the Medicare ALJs in HCFA, it will be easier for the agency to coordinate and provide proper training for the corp and mandate attendance.

- Develop and Require Medicare Contractors and ALJs to Apply the Same Standards -
  We agree that contractors and ALJs should be bound by the same rules and standards. We plan to bind ALJs to the same standards our contractors are bound to, including all coverage policy and contractor manuals in our forthcoming regulations. We will publish significant Medicare Appeals Council decisions as HCFA Rulings, making those decisions precedential. In addition, we believe that enhanced ALJ education will foster the use of common rules of decision, since ALJs will better understand the rules and policies upon which the contractors are making their decisions.

- Develop Regulations for Conducting Medicare ALJ Appeals -
  We agree and plan to begin soon development of HCFA regulations for both the Part A and Part B appeals process with the input of the ALJs in the Medicare cadre.

- Establish a Case Precedent System for DAB Rulings -
  We agree that certain important decisions should be published and perhaps even made binding. We will evaluate the possibility of establishing a case precedent system for DAB Rulings.

- Create Formal Communication and Information Networks That Span the Entire Appeals Environment -

  We agree that information sharing is key to a successful appeals process. As mentioned above, we will publish important local medical review policies as HCFA Rulings and make them available to ALJs, and we will develop a process for making decisions of significance available to other ALJs and to the Appeals Council as well. In addition, we believe that enhanced ALJ and contractor education programs will foster common knowledge among ALJs and contractors. We continue to encourage contractors to invite ALJs to training at the contractor sites and to remain available to ALJs for further consultation and education.

OIG Recommendation
Establish a Dedicated ALJ Corps for Medicare Appeals

HCFA Response
We believe that a HCFA ALJ corps would be the most efficient means for deciding appeals. HCFA should have the responsibility for managing the ALJ function for Medicare claims, as the administrator of the Medicare Program. Because the ALJ function is outside of HCFA, the agency has not had the requisite control to adequately manage the ALJ appeals process. HCFA has a vested interest in improving the process, in terms of both program integrity and customer service. HCFA is accountable to its customers and to the public/taxpayers to assure excellence in all aspects of the program, including Medicare appeals. The ALJ function should be located in an organizational structure within HCFA that will ensure ALJ decisional independence. The ALJ function should be placed in a separate and distinct HCFA Office with the direct delegation of authority from the Secretary to perform ALJ hearings and total organizational separation from HCFA's other activities, with its Senior Leadership reporting directly to the Administrator. We have prepared a budget estimate and submitted it for inclusion in the President's FY 2001 budget that will support transfer of the ALJs to HCFA.

Again, we appreciate the work of the OIG in this important area and thank you for your valuable and timely recommendations.